STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155505	A. BUILDING 01 B. WING	09/01/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROBIN RUN HEALTH CENTER	6370 ROBIN RUN W INDIANAPOLIS, IN46268

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K0000	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a). Survey Date: 09/01/11 Facility Number: 01156 Provider Number: 155505 AIM Number: 100453350 Surveyor: Mark Caraher, Life Safety Code Specialist At this Life Safety Code survey, Robin Run Health Center was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This one story facility was determined to be of Type V (111) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, resident rooms and areas open to the corridor. The facility has a capacity of 84 and had a census of 67 at the time of	K0000	The following is the Plan of Correction for Robin Run Healthcare Center regarding the Statement of Deficiencies dated 9/2/11. This Plan of Correction is not to be construed as an admission of or agreement with the finings and conclusions in the Statement of Deficiencies, or any related sanction or fine. Rather, it is submitted as confirmation of our ongoing efforts to comply with statutory and regulatory requirements. In this document, we have outlined specific actions in response to identified issues. We have not provided a detailed response to each allegation or finding, nor have we identified mitigating factors. We remain committed to the delivery of quality health care services and will continue to make changes and improvement to satisfy that objective.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155505	A. BUILDING 01 B. WING	09/01/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROBIN RUN HEALTH CENTER	6370 ROBIN RUN W INDIANAPOLIS, IN46268

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	this survey. Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 09/02/11. The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:			
K0076 SS=E	Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities. (a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation. (b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. NFPA 99 4.3.1.1.2, 19.3.2.4 Based on observation and interview, the facility failed to ensure 1 of 2 oxygen storage locations of greater than 3000 cubic feet was separated a minimum distance of at least five feet from combustible materials. NFPA 99, 8-3.1.11.2(c) requires oxidizing gases such as oxygen shall be separated from combustibles by a minimum distance of five feet if the required storage location is protected by an automatic sprinkler system. This deficient practice could affect any resident, staff or visitor in the vicinity of the oxygen storage and	K0076	I. All residents have the potential to be affected by the deficient practice. The deficient practice was immediately corrected by relocating the four shelf storage rack containing combustible linen supplis, blankets, towels and clothing out of the oxygen storage area.II. All residents residing at the facility have the potential to be affected by the deficient practice. The facility will conduct a daily facility round to ensure that the oxygen storage locations are separated a distance of five (5) feet from combustible materials.III. In order to prevent	09/01/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155505	A. BUILDING 01 B. WING	09/01/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROBIN RUN HEALTH CENTER	6370 ROBIN RUN W INDIANAPOLIS, IN46268

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	transfilling room in the Clare Bridge Hall. Findings include: Based on observation with the Director of Plant Operations during a tour of the facility from 11:55 a.m. to 2:00 p.m. on 09/01/11, the oxygen storage and transfilling room in the Clare Bridge Hall contained one liquid oxygen canister which was 75% full. Within three feet of the liquid oxygen storage canister was a four shelf storage rack which contained combustible linen supplies, blankets, towels and clothing. Based on interview at the time of observation, the Director of Plant Operations acknowledged combustible supplies were stored within three feet of the liquid oxygen canister in the Clare Bridge oxygen storage and transfilling room. 3.1-19(b)		the deficient practice from recurring, the facility will inservice all maintenance staff on the storage required distance to maintain resident safety. IV. The facility will monitor the corrective actions by the Director of Engineering and/or designee performing rounds daily for one month and weekly for one month. The results will be reviewed at the facility's Quality Assurance Committee and revisions will be made if needed and as directed by the committee. The Director of Engineering Services will ensure ongoing monitoring after the aforementioned monitoring period.V. The deficient practice was completed on 9/1/11.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155505	A. BUILDING 01 B. WING	09/01/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROBIN RUN HEALTH CENTER	6370 ROBIN RUN W INDIANAPOLIS, IN46268

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K0143 SS=E	Transferring of oxygen is: (a) separated from any portion of a facility wherein patients are housed, examined, or treated by a separation of a fire barrier of 1-hour fire-resistive construction; (b) in an area that is mechanically ventilated, sprinklered, and has ceramic or concrete flooring; and (c) in an area posted with signs indicating that transferring is occurring, and that smoking in the immediate area is not permitted in accordance with NFPA 99 and the Compressed Gas Association. 8.6.2.5.2 1. Based on observation and interview, the facility failed to ensure 2 of 2 liquid oxygen storage areas were provided with signage indicating oxygen transferring is occurring. This deficient practice could affect any residents, staff or visitor in the vicinity of the oxygen storage and transfilling room near Room 30 and in the oxygen storage and transfilling room in the Clare Bridge Hall. Findings include: Based on observations with the Director of Plant Operations during a tour of the facility from 11:55 a.m. to 2:00 p.m. on 09/01/11, the oxygen storage and transfilling room near Room 30 and the oxygen storage and transfilling room in the Clare Bridge Hall each were not provided with a sign indicating	K0143	I. All residents have the potential to be affected by the deficient practice. The deficient practice was immediately corrected by applying door signage indicating that oxygen is transfering. The deficient practice was completed by disconnecting the fan from the on/off switch to allow for proper ventilation in the oxygen transfilling room. II. All residents residing at the facility have the potential to be affected by the deficient practice. The facility will conduct a daily facility round to ensure that the oxygen transferring signs are afixed to the oxygen room doors and that the oxygen transfilling room on Clare Bridge is properly ventilated.III. In order to prevent the deficient practice from recurring, the facility will ensure compliance of the permanent signage to the doors where liquid oxygen is transferring and the	09/01/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155505	A. BUILDING 01 B. WING	09/01/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROBIN RUN HEALTH CENTER	6370 ROBIN RUN W INDIANAPOLIS, IN46268

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	transferring of oxygen was occurring. Based on interview at the time of observation, the Director of Plant Operations stated the transferring of oxygen does occur in each oxygen transfilling room and acknowledged each oxygen storage and transfilling room was not provided with a sign indicating transferring of oxygen was occurring in each oxygen storage and transfilling room. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure 1 of 2 liquid oxygen storage and transfilling rooms was provided with continuous mechanical ventilation. This deficient practice could affect any residents, staff or visitor in the vicinity of the oxygen storage and transfilling room in the Clare Bridge Hall. Findings include: Based on observation with the Director of Plant Operations during a tour of the facility from 11:55 a.m. to 2:00 p.m. on 09/01/11, the oxygen storage and transfilling room in the Clare Bridge Hall which is used to store one liquid oxygen canister was not provided with continuous mechanical ventilation. A mechanical vent was observed in operation but it was		facility will ensure proper ventilation to the oxygen transfilling room.IV. The facility will monitor the corrective actions by the Director of Engineering and/or desginee completing a weekly observation for one month then a monthly observation for three months. The results will be reviewed at the facility's Quality Assurance Committee and revisions will be made if needed and as directed by the committee.V. The deficient practice was completed on 9/1/11.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155505	A. BUILDING 01 B. WING	09/01/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROBIN RUN HEALTH CENTER	6370 ROBIN RUN W INDIANAPOLIS, IN46268

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	shut off with the room's light switch. Based on interview at the time of observation, the Director of Plant Operations acknowledged the oxygen storage and transfilling room was not provided with continuous mechanical ventilation. 3.1-19(b)			
K0144 SS=F	Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1. Based on observation and interview, the facility failed to ensure 1 of 2 emergency generators was equipped with a remote manual stop. NFPA 99, Health Care Facilities, 3-4.1.1.4 requires generator sets installed as alternate power sources shall meet the requirements of NFPA 110, Standard for Emergency Standby Power Systems. NFPA 110, 3-5.5.6 requires Level II installations shall have a remote manual stop station of a type similar to a break glass station located outside of the room where the prime mover is located. NFPA 110, 7-1 states NFPA 37, Standard for the Installation and Use of Stationary Combustion Engines and Gas Turbines, contains mandatory requirements for emergency generators and shall be considered part of the requirements of this standard. NFPA 37, 8-2.2(c) requires	K0144	I. All residents have the potential to be affected by the deficient practice. The deficient practice was completed on 9/7/11 by a vendor contracted to install an emergency stop switch on the generator.II. All residents residing at the facility have the potential to be affected by the deficient practice. The facility corrected the deficient practice by a vendor contracted install an emergency stop switch on the generator.III. In order to prevent the deficient practice from recurring, the emergency stop switch installed on the generator and will be monitored to ensure proper functioning of the switch.IV. The facility will monitor the corrective actions by the Director of Engineering and/or desginee ensuring proper functioning weekly for one month then a monthly for three months.	09/07/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155505	A. BUILDING 01 B. WING	09/01/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROBIN RUN HEALTH CENTER	6370 ROBIN RUN W INDIANAPOLIS, IN46268

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	engines of 100 horsepower of more have provisions for shutting down the engine at the engine and from a remote location. This deficient practice could affect all residents, staff and visitors. Findings include: Based on observations with the Director of Plant Operations during a tour of the facility from 11:55 a.m. to 2:00 p.m. on 09/01/11, evidence of a remote shut off device was not found for the 125 kW diesel fired emergency generator which services the health care portion of the facility. Based on interview at the time of observation, the Director of Plant Operations stated the emergency generator was installed prior to 2003 and acknowledged there is no remote emergency shut off device for the generator. 3.1-19(b)		The results will be reviewed at the facility's Quality Assurance Committee and revisions will be made if needed and as directed by the committee. The Director of Engineering will ensure that monitoring will be continual after the aforementioned monitoring is complete.V. The deficient practice was completed on 9/1/11.	